AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF MISSISSIPPI
COUNTY OF Jones

Personally appeared before me, the undersigned authority in and for the aforesaid jurisdiction, Jamara Lofton, who, after being duly sworn, did depose and say:

1. I am the duly authorized custodian of the records attached to this Affidavit;

2. I have first-hand knowledge about the making, maintenance and storage of the attached records;

3. The attached records are a true and correct copy of medical records regarding Albert L. Graham, DOB, [redacted] Social (last 4): [redacted] as kept on file at the office of Ellisville Medical Care;

4. The attached records were:

   a. Made at or near the time of the occurrence of the matters set forth therein by, or from information transmitted by, a person with knowledge of those matters;
   b. Kept in the course of regularly conducted activity; and
   c. Made as part of the regular practice of the business, institution, association, profession, or occupation.

BY: Ellisville Medical
NAME: Jamara Lofton
TITLE: Registration

SWORN TO AND SUBSCRIBED BEFORE ME this the 23 day of OCT, 2013.

Leah B Morris
NOTARY PUBLIC

MY COMMISSION EXPIRES:

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 59760 LEAH B. MORRIS Commission Expires Feb. 14, 2016 JONES COUNTY

EXHIBIT 3

PLEASE PRINT CLEARLY

ELLISVILLE MEDICAL CLINIC
A Division of South Central Regional Medical Center

Chart: _____

PATIENT INFORMATION

Name: Albert L Graham Date of Birth: [redacted] SEX: (M) F

Address: [redacted] City: Laurel State: MS ZIP: 39443 County: Jones

Home Phone: 601 [redacted] Work Phone: None Cell Phone: 601- [redacted]

Social Security #: [redacted] Full Time Student: Yes / (No) Employer: NO

Employer Address: None Are phone calls allowed? Yes / No

Marital Status: Single / (Married) / Divorced / Widow Spouse Name: Jeanetta B. Graham

GUARANTOR INFORMATION (Complete if Patient is Under Age 18)

Name: _____ Date of Birth: _____ SEX: M / F

Address: _____ City: _____ State: _____ ZIP: _____ County: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Relationship to Patient: _____

Employer Address: _____ Are Phone Calls Allowed? Yes / No

EMERGENCY CONTACT INFORMATION (Please list someone who does not live with the patient)

Name: James Graham Contact Number: 228- [redacted]

Address: [redacted] Moss MS Relationship to Patient: Brother

INSURANCE INFORMATION: (We must obtain copies of all insurance cards)

Primary Insurance: None Name of Insured: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____ Name of Insured: _____

ID Number: _____ Group Number: _____

As a courtesy to our patients, Ellisville Medical Clinic will file your insurance claim. All co-pays, co-insurance amounts or deductibles are due at the time of service. It is the responsibility of the patient to verify their provider is listed in network with their insurance plan. Patients will receive a statement for balances that are not paid or adjusted by our agreement with your insurance plan.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of service and by signing this agreement as a patient or an agent of a patient in consideration of treatment and services to be rendered to the named patient, I obligate myself to pay the account due to Ellisville Medical Clinic in accordance with regular rates and terms for such treatment and services deemed necessary by Ellisville Medical Clinic physicians or staff and rendered to the patient, and hereby unconditionally guarantee payment of the patient's account to Ellisville Medical Clinic Unless otherwise agreed in writing, payment under this guaranty shall be made by the undersigned within 30 days after receipt of a statement from EMC. Should the account become delinquent and referred to a collection agency or attorney for collection, the undersigned agrees to pay any and all reasonable collection agency and/or attorney fees.

In the event that the person signing this agreement is entitled to benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to patient, said benefits are hereby assigned to Ellisville Medical Clinic for the application on the patient's account and such payments shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment. The person signing this agreement authorizes Ellisville Medical Clinic to refund all or any part of insurance benefits received by EMC upon demand and representation of any and all insurance carriers that any payment was made in error. It is understood and agreed that the assignment of benefits from any and all insurance carriers does NOT relieve the undersigned or patient from obligation by the person signing this agreement or patient, if such benefits from the insurance company have not been received. I, the patient or agent of a patient signing this agreement, authorize Ellisville Medical Clinic physicians and staff to release to my insurance company or responsible party for payment of services.

AUTHORIZATION FOR TREATMENT

I hereby authorize and request examination and/or medical treatment by the physicians and staff of Ellisville Medical Clinic. I further authorize EMC physicians and staff to administer such treatment as necessary, and such additional procedures, tests, and interpretations as are considered therapeutically necessary and medically advisable on the basis of findings during the course of treatment. I further consent to the presence of others, such as representatives of providers of medical devices and pharmaceuticals, and students of accredited medical education programs as permitted by my physician during my treatment. I certify that no guarantee or assurance has been made as to the results that may be obtained. I certify that I have read and fully understand the above authorization for medical treatment. Ellisville Medical Clinic recognizes the patient's right to privacy, confidentiality, and safety.

Albert L Graham 3-10-010

PATIENT OR LEGAL GUARDIAN DATE

ELLISVILLE MEDICAL CLINIC
A Division of South Central Regional Medical Center

NOTICE OF PRIVACY PRACTICED FOR PROTECTED HEALTHCARE INFORMATION

Ellisville Medical Clinic has provided me with a copy of its Notice of Privacy Practices for Protected Health Information. I under stand this Notice describes how my medical information will be protected. I understand the Healthcare Insurance Portability and Accountability Act o f 1996 (HIPAA) required Ellisville Medical Clinic to protect my information. I understand how Ellisville Medical Clinic may use and disclose my health information. I received Version #_____ of the Privacy Notice.

I acknowledge the receipt of the Notice of Privacy Practices.

Albert Graha — 3-10-010
PATIENT OR LEGAL GUARDIAN — DATE

PATIENT HEALTH/PATIENT ACCOUNT INFORMATION PERMISSION

According to the Health Insurance Portability and Accountability of 1996 (HIPAA), Ellisville Medical Clinic is not authorized to discuss your medical information or patient account information with anyone but the patient. Sometimes, this is not always convenient or possible. If you wish your information to be discussed with any individual other than yourself you must complete the information below:

I give my permission to release any information regarding my medical care which may include, but is not limited to appointment times, lab results, medications, etc. I understand that my records are confidential and with my signature below it will allow the release of my medical information to the following people.

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

Albert L. Graha — 3-10-010
PATIENT SIGNATURE — DATE

WITNESS SIGNATURE — DATE

Medication List

Patient Name:_____ DOB:_____

Medication	Date Checked Below	3/10/10									
	ϕ	✓									

Other Information:

Problem List

Patient Name:_____ DOB:_____ Chart#:_____

Date	Diagnosis/ Condition	Active	Resolved	How Resolved
	HTN			
	Hx CVA by hx.			
	CHF			
	Seizure			

Operative/ Invasive Procedures	
Appendectomy 1963 or 64	

Consults	Procedures	Vaccinations
Dr Mouannes		

Family History	Social History
Please List: F ↓ HTN, stroke age 55	Do you use any tobacco products? Prev. Smoked
	Do you consume alcohol? Prev. beer
	What is your marital status?
	Where do you work? Worked @ Ship Yard

Patient Name _____ Age _____

T 96.8 BP 114/75 Allergies: NKDA

R _____ P 94

HT _____ WT _____

LMP _____ NORM ABN

Current Meds: None Noted on Med Summary Sheet

HISTORY/CHIEF COMPLAINT: (LOCATION, CONTEXT, QUALITY, SEVERITY, DURATION, TIMING, ASSOC. S/S, MODIFYING FACTORS)

F.U. HTN > no med. 6 mos, for BP
? CHF > Cores none since Nov. 09.
Dr Mouannes in card.

hx also of Stroke Seizure prev. on Coumadin

Hx Limited by: ___ Patient required immediate medical intervention ___ Patient unable to provide hx ___ Other _____

Pain Yes ___ No ✓ Intensity Score ___ (0-10) If the pain intensity score is greater than 3, complete pain assessment below.
Onset: When did it start _____ Duration: How long does it last? _____
Location: _____ Quality: Sharp ___ Ache ___ Burn ___ Throb ___ Other _____
Method of relief: Medication Yes ___ No ___ Other
Other Symptoms: Nausea ___ SOB ___ Insomnia ___ Other _____
Does your pain interfere with your daily activities Yes ___ No ___ If Yes, what activities _____
Pain level at best _____ at worst _____ Acceptable level of pain _____ (during past 24 - 72 hours)
Comments: _____

Signature/Date 3/10/10

REVIEW OF SYSTEMS: (+) Positive or Abnormal (- or ✓) Negative or Normal

CONST: Wt. Loss ___ Fever ___ Body Aches ___ Dizziness ___ GU: Dysuria ___ Frequency ___ Hematuria ___ Genital Discharge ___
EYES: Vision Loss ___ Pain ___ Redness ___ Discharge ___ Visual Change ___ NEURO: H/A 2 Weakness ___ Numbness ___ Tingling ___ Seizure ___
ENMT: Hearing Loss ___ Pain Discharge ___ Sore Throat ___ Dysphagia ___ SKIN/BREAST: Rash ___ Cellulitis ___ Lesions ___ Eruptions ___ LAC ___
RESP: SOB 2 Cough 2 Wheezing 2 Sputum ___ Hemoptysis ___ PSYCH: Depression ___ Anxiety ___ Hallucinations ___ Suicidal ___
CV: CP 2 Palpitations ___ Edema 1+ Cyanosis ___ Orthopnea ___ HEME/LYMPH: Anemia ___ Abnormal Bleeding ___ Nodes ___
GI: Abd Pain ___ N/V/D ___ Constipation ___ Melena ___ Change in bowel habits ___ ALLERGY/IMMUNO: Rash ___ Pruritis ___ Wheezing ___
MS: Pain ___ Swelling ___ Deformity ___ Redness ___ ROM ___ ENDO: Goiter ___ Polyurea ___ Polydipsia ___ Cold Intolerance ___
ALL OTHER SYSTEMS ARE NEGATIVE ___

COMMENTS: off all meds x 6 mo. needs HTN med refilled.
pt in jail

PAST MEDICAL HX: No signif. PMH ___ HTN ___ DM ___ PUD ___ HD ___ M.I. ___ Angina ___ Psych ___ Migraine ___ Asthma ___
CVA ___ Kidney Stone ___ COPD ___ CHF ___ Seizure ___ Other ___
PAST SURGICAL HX: None ___ Appy ___ Hysterectomy (Complete/Partial) ___ Herniorrhaphy ___ Cholecystectomy ___ Other _____
SOCIAL HX: Single ___ Married ___ Employed ___ Disabled ___ Smokes: Yes ___ PPP ___ No ___ ETOH: None ___ Occasional ___ Moderate ___ Daily ___
ETOH Abuse ___
Comment: med pt
Here

FAMILY HX: None pertinent ___ DM ___ HTN ___ CAD ___ Asthma ___ Seizures ___ Other _____

DO NOT WRITE BELOW THIS LINE

SOUTH CENTRAL ELLISVILLE MEDICAL CLINIC
ELLISVILLE, MISSISSIPPI 39437

ELLISVILLE CLINIC PROGRESS NOTES

ELPNOTES Rev. 08-2001 Pilot Form

DO NOT WRITE BELOW THIS LINE

PATIENT BARCODE

Albert Graham
[redacted]
3-10-10

HC000068

PHYSICAL EXAM: (+) Positive or Abnormal (- or ✓)

SKIN:	Skin and Subcutaneous Tissue ___ Palpation of Skin ___ Rash ___ Warm ✓ Dry ✓ Cool ___ Moist ___
LYMPH:	Palpation of Lymph Nodes: Neck ___ Axilla ___ Groin ___ Other: ___
NEURO:	Cranial Nerves ___ Deep Tendon Reflexes ___ Sensation ___ Ataxia ___ Tremors ___ Nystagmus ___
PSYCH:	Judgement and Insight ✓ Orientation to Person, Place, Time ✓ Recent/Remote Memory ✓ Mood/Affect ___ Suicidal/Homicidal ___
CONST:	General Appearance healthy
EYES:	Conjunctiva and lids ✓ Pupils and Irises ___ Optic discs and Posterior Segments ___ EOMI ___ Nystagmus ___ Anterior Chamber ___
ENMT:	Ears and Nose ___ Canals and TMS ___ Hearing ___ Lips, Teeth, and Gum ___ Nasal Mucosa ___ Septum and Turbinates ___ Oropharynx ___ Oral mucosa ___ Salivary Glands ___ Palate ___ Tongue ___ Tonsils and Posterior Pharynx ___
NECK:	Neck ___ Thyroid ___ JVD ___ ___ Tracheal Position ___ supple
CV:	Palpation of Heart ___ Auscultation of Heart/Abnormal Sounds/Murmurs ___ Carotid Arteries ___ Abdominal Aorta ___ Femoral arteries ___ Pedal Pulses ___ Edema/Varicosities in Extremities ___ RRR all in ankle
RESP:	Respiratory Effort ___ Percussion of Chest ___ Palpation of Chest ___ Auscultation of Lungs ___ NAD Cl
CHEST:	Breasts ___ Palpation of Breasts/Axilla ___ Breast Symmetry ___ Chest Wall ___
GI:	Masses or Tenderness ___ Bowel Sounds Present ___ Liver and Spleen ___ Rectal Exam: Hemorrhoids, Tone, Masses ___ Stool for Occult Blood (When indicated) ___
GU:	MALE: Scrotal Contents ___ Penis ___ Prostate Gland ___ Discharge ___ Hernia ___ FEMALE: Pelvic Exam ___ External Genitalia ___ Uterus ___ Bladder ___ Cervix ___ Adnexa ___ Urethra ___ CMT ___
MS:	Gait and Station ___ Digits and Nails ___ Deformity, Tenderness, Masses and Effusions ___ ROM, Pain, Crepitation or Contracture ___ Stability, Dislocation/Subluxation, Laxity ___ Strength and Tone, Atrophy or Abnormal Movements ___

Impression: HTN

Plan: Cotenin 10/12.5 # 80 QD
RC ✓ B/P ↑ 2d

Education: CH7/ HTN

Follow-Up: ___

Orders: ___

Supplies: ___

Clinician Signature: [signature]

Physician Signature: ___

DO NOT WRITE BELOW THIS LINE

DO NOT WRITE BELOW THIS LINE

Albert Graham

[redacted]

3-10-10

.NOTE2

HC000069

ELLISVILLE MEDICAL PARK

A Division of South Central Regional Medical Center

TELEPHONE TRIAGE FORM

Date: 6.3.10 Time: 10:40

Patient: Albert Graham Patient Phone#: _____

MR#: [redacted] DOB: [redacted]

Provider: DS Pharmacy: _____

Name of Caller: Jeanettie Phone # of Caller: [redacted]

Relationship to Patient: wife

Message:

very rude – said she asked to speak to Donnie, not Sharon.

calling to check on husband's meds

Response:

Receptionist: JH Time Placed in Rack: _____

Nurse: _____ Date: _____ Time: _____

Provider: _____ Date: _____ Time: _____

ELLISVILLE MEDICAL PARK

A Division of South Central Regional Medical Center

TELEPHONE TRIAGE FORM

Date: 6-2-10 Time: 4:16

Patient: Albert Graham Patient Phone#: [redacted]

MR#: [redacted] DOB: [redacted]

Provider: DS Pharmacy: _____

Name of Caller: Jeanetta Graham Phone # of Caller: [redacted]

Relationship to Patient: wife

Message: Mr. Graham passed away. He gave him a medicine and she wants to know what it is

Response: Blood pressure

LM 8-32

Receptionist: _____ Time Placed in Rack: _____

Nurse: SBar Date: _____ Time: _____

Provider: _____ Date: _____ Time: _____

ELLISVILLE MEDICAL PARK
1203 Avenue B
Ellisville, MS 39437

Patient Name: **GRAHAM, ALBERT L**
DOB/Age: [redacted] 58 years
FIN: EMP#103853
MRN: [redacted]
Location/Rm: E.FamilyMedicine
Admit Date: 03/10/2010
Attending Phy:
Ordering Phy: Donald T. Scoggin, CFNP

*****EXPEDITE REPORT*****

Chemistry

Chemistry / Profiles

Collected Date 03/10/2010
Collected Time 13:42

Procedure		Units	Ref Range
Sodium	139.6	mmol/L	[135.0-149.0]
Potassium	4.2	mmol/L	[3.5-5.3]
Chloride	**111.2 H**	mmol/L	[96.0-110.0]
Co2	24.2	mmol/L	[23.0-33.0]
Calcium	**8.5 L**	mg/dL	[8.6-10.6]
Bun	**23 H**	mg/dL	[5-20]
Creatinine	1.1	mg/dL	[0.6-1.2]
Glucose	108	mg/dL	[70-115]
Osmolality(Calc)	282.9	mOsm/kg	[270.0-290.0]
Bun/Cr Rat(Calc)	**20.72 H**		[12.00-20.00]
Anion Gap (Calc)	4.2		